DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND ADDICTIVE DISEASES

CORE REQUIREMENTS FOR CRISIS STABILIZATION PROGRAMS FOR CHILDREN AND YOUTH

Effective July 1, 2005

The following requirements for Crisis Stabilization Programs for Children and Youth have been built from the Core Requirements for Crisis Stabilization Programs serving adults that were implemented in July of 2000, and have been modified to address issues around children and youth.

The CSP standards document has been footnoted to indicate modifications and additions to the standards since their inception. Crisis Stabilization Program standards that arose from issues resulting from the Certificate of Need concern addressed in the "Letter of Agreement" between the Department of Community Health and DHR Division of MHDDAD, signed on the 28th day of February, 2001 by George P. A. Newby, representing DCH and by Jerry Lovrien, representing DHR, have not been modified.

Crisis Stabilization Program standards for children and youth are incorporated by reference into those found in the State of Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases document entitled "Core Requirements for All Providers".

SSr 11.1. DESCRIPTION OF THE PROGRAM

SSr 11.1(a). The Crisis Stabilization Program for children and youth is a medically monitored short-term residential service operated by the Community Service Board[4] for the purpose of providing psychiatric or behavioral stabilization for children and youth who are seriously emotionally disturbed and detoxification services for youth. The crisis stabilization program must be designated by the Department as both an emergency receiving facility and an evaluating facility.

Interpretive guideline 1: The department may designate [as emergency receiving, evaluating and treatment facilities] any private facility or such portion of a certified community mental health and substance abuse program which complies with the standards for a CSP within the State of Georgia at the request of or with the consent of the governing officers of such facility. Rules of DHR MHMRSA ERETF 290-4-1-.02(a). Et. Seq.

Interpretive guideline 2: As defined in the Rules of DHR MHMRSA ERETF 290-4-1-.01(b), the term "Crisis Stabilization Program ("CSP") means a short term residential program operated as a part of a comprehensive community mental health and substance abuse program

[4] CSP's may be state operated effective FY04

[operated by a Community Service Board or by a Divsion of MHDDAD state hospital facility][4] for the purpose of providing psychiatric stabilization or detoxification services, which complies with applicable standards in the "Standards for Community Mental Health, Developmental Disabilities and Addictive Diseases Services" [DHR Division of MHDDAD "Core Requirements for All Providers" contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of MHDDAD*].

Interpretive guideline 3: Crisis stabilization programs are state authorized residential services provided as a part of a Community Service Board[4] and designed to serve as a first line alternative to hospitalization in state hospitals, offering psychiatric or behavioral stabilization and detoxification services on a short term basis. CSP's for children and youth are not designed to provide 'study and report' services or to be available for court ordered placement for the purpose of temporary placement only.

Interpretive guideline 4: The target population served in the CSP is children and youth ages 5-17 requiring psychiatric or behavioral stabilization and youth ages 13-17 with substance related disorders or with co-occurring mental health and substance use needs.

Interpretive guideline 5: Youth through age 21 may be served at a Crisis Stabilization Program for Children and Youth *provided* it is indicated clinically and is based on the youth's maturational age. The Medical Director must approve such admissions.

Interpretive guideline 6: Residential detoxification services offered within the CSP **shall not exceed** services described in Level III.7 of the Adolescent Criteria section of the *American Society for Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM PPC-2R), Second Edition, April 2001.

Interpretive guideline 7: NOTE: Twenty-four hour residential services offering detoxification ONLY shall be licensed by the Georgia Department of Human Resources Office of Regulatory Services under the "Rules of Department of Human Resources Chapter 290-4-2: Drug Abuse Treatment and Education Programs". These CSP standards shall not apply.

Interpretive guideline 8: Psychiatric stabilization services offered within the CSP **shall not exceed** services described in Level Six of the C*hild and Adolescent Level of Care Utilization System for Psychiatric and Addiction Services,* Version 1.5 (CALOCUS), published by the American Association of Community Psychiatrists.

Interpretive guideline 9[2]: The term "emergency receiving facility" means a facility designated by the department to receive patients under emergency conditions as provided in Part 1 of Article 3 of Chapter 3 or of Chapter 7 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(d).

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[4] CSP's may be state operated effective FY04
[2] Added to CSP Standards FY02

Interpretive guideline 10[2]***:*** The term "evaluating facility" means a facility designated by the department to receive patients for evaluation as provided in Part 2 of Article 3 or of Chapter 7 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(e).

Interpretive guideline 11[2]*:* Certification reviews will be conducted for physical plant, safety and food service according to the specifications outlined in the Rules for Drug Abuse Treatment & Education Programs, Chapter 290-4-2, section .11 "Physical Plant and Safety" and section .12 "Food Service".

Interpretive guideline 12[6]*:* CSP's that are newly constructed or CSP's undergoing physical plant modifications after June 30, 2005 shall address safety issues to minimize the opportunity for self-harm of an individual such as, but not limited to the following:

a. Shower fixtures in bathrooms shall be flush-mounted in the wall
b. Headers supporting bathroom stalls shall be flush-mounted to the ceiling
c. There shall be two avenues of visual access into the seclusion and restraint room, one of which shall be through a window in the door to the room.
d. Blind spots on the unit shall be addressed through use of convex mirrors allowing for visual access A room used for seclusion or restraint must:
    i. Allow staff full view of the resident in all areas of the room;
    ii. Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets
e. Video cameras are not a permitted alternative to direct observation of an individual in the seclusion or restraint room
f. Doors to bedrooms shall be hung on hinges that swing both in to the room and out from the room. [7]Note that if a building is being *modified* and it is not possible for the door to swing both ways, the door should be mounted to open away from the room.

SSr 11.1(b). The Crisis Stabilization Program shall describe its capacity to serve voluntary and involuntary residents.

Interpretive guideline 1[6.1]*:* The program description of the CSP clearly describes its service mission including its capacity to carry out the emergency receiving and evaluating functions of the CSP.

SSr 11.1(c). The Crisis Stabilization Program is NOT a designated treatment facility as defined by O.C.G.A. 37-3 and 37-7.

Interpretive guideline 1: The term 'treatment facility' means a facility designated by the department to receive patients for treatment as provided in Part 3 of Article 3 of Chapter 3 of Title 37. Rules of DHR MHMRSA ERETF 290-4-1-.01(f).

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[6] Added to CSP Standards FY06
[7] Added to CSP Standards FY07
[6.1] Modified FY06

Interpretive guideline 2: The program description of the CSP clearly states that it is not a designated treatment facility as provided in Part 3 of Article 3 of Chapter 3 of Title 37.

SSr 11.1(d). The Crisis Stabilization Program shall not use the word "inpatient" anywhere for any purpose to describe the services offered within the CSP.

Interpretive guideline 1: The program description and all other documents within the CSB and CSP shall describe the services offered within the CSP as *residential* services.

SSr 11.1(e). The Crisis Stabilization Program shall not hold itself out as a hospital or bill as a hospital for inpatient services.

Interpretive guideline 1: There is no evidence that the CSP is holding itself out as a hospital or that it is billing for hospital or inpatient services.

SSr 11.1(f).[2] The CSP shall not operate in a manner or offer any service that brings it within the purview of Georgia's Certificate of Need (CON) Program as defined by the CON Statue and Rules (O.C.G.A. 31-6-1 et. seq. and O.C.R.R. 272-2-1 et. seq.).

Interpretive guideline 1: There is no evidence that the CSP is operating in a manner or offering any service that brings them within the purview of Georgia's Certificate of Need (CON) Program.

SSr 11.2 CERTIFICATION OF THE CRISIS STABILIZATION PROGRAM

SSr 11.2. The Crisis Stabilization Program shall be surveyed for compliance with State standards.

Interpretive guideline 1: Any Crisis Stabilization Program (CSP), to be eligible for designation, shall be a part of a comprehensive community mental health and substance abuse program which comprehensive program has been certified by the Division of Mental Health, Developmental Disabilities and Addictive Diseases to be in compliance with: 1) Standards for Community Mental Health, Developmental Disabilities and Addictive Diseases Services [DHR Division of MHDDAD "Core Requirements for All Providers" contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of MHDDAD*], and 2) the Department of Human Resources Grants to Counties Policy Manual. Rules of DHR MHMRSA ERETF 290-4-1-.02(d).

Interpretive guideline 2[6]: Any state operated Crisis Stabilization Program (CSP), to be eligible for designation, shall be operated by an accredited and licensed (if applicable) healthcare authority and shall be certified by the Division of Mental Health, Developmental Disabilities and Addictive Diseases to be in compliance with: 1) Standards for Community Mental Health,

[2] Added to CSP Standards FY02
[6] Added to CSP Standards FY06

Developmental Disabilities and Addictive Diseases Services [DHR Division of MHDDAD "Core Requirements for All Providers" contained within the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of MHDDAD*].

SSr 11.3. LINKAGES FOR COMPLEX CARE NEEDS

SSr 11.3. The Crisis Stabilization Program shall have operating agreements with private and public inpatient hospitals and treatment facilities.

Interpretive guideline 1: Crisis Stabilization Programs shall have documented operating agreements and referral mechanisms for psychiatric, addictive disorder and physical health care needs that are beyond the scope of the Crisis Stabilization Program and that require inpatient treatment. Operating agreements shall delineate the type and level of service to be provided by the private or public inpatient hospital or treatment facility.

Interpretive guideline 2: The following shall be clearly stated within the body of the operating agreements between the CSP and designated treatment facilities(s):

> "The purpose of clinical services provided by the CSP are psychiatric or behavioral stabilization for children and youth who are severely emotionally disturbed and detoxification for youth ages 13-17 with substance related disorders or co-occurring mental health and substance use needs."

Interpretive guideline 3: The CSP shall have an agreement that makes available medical pediatric services for children and youth.

Interpretive guideline 4: The private facility or the CSP shall utilize available resources in the community to provide psychological tests and social work services if such services are needed for the patients and do not exist within the facility. Rules of DHR MHMRSA ERETF 290-4-1-.04(4).

SSr 11.4. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

SSr 11.4. The Crisis Stabilization Program will operate within the guidelines of EMTALA with respect to stabilization and transfer of residents.

Interpretive guideline 1: The Crisis Stabilization Programs are not hospitals nor do they receive Medicare monies. However, the CSP's will operate within the guidelines of EMTALA with respect to the stabilization and transfer of residents to and from hospitals.

SSr 11.5. LENGTH OF STAY

SSr.11.5[2.1]. The average annual length of stay shall not exceed nine (9) days excluding Saturdays, Sundays and Holidays.

Interpretive guideline 1: For any one episode of care, an individual child or youth may not remain in a CSP beyond 14 days, excluding Saturdays, Sundays and Holidays, with the exception described in Interpretive Guideline 2 below.

Interpretive guideline 2[4.1]: A CSP must designate transitional beds separate from crisis residential beds. Residents occupying transitional beds may remain in the CSP beyond 14 days excluding Saturdays, Sundays and Holidays **only if they are in services and activities on a daily basis that indicate the resident is actively engaged in transitioning to the community**. The CSP must record the date of transfer to the transitional bed(s) and the length of stay in transitional beds for each episode of transitional care. Transitional bed designation should be made using these parameters:

a. A CSP with up to 29 beds may designate one or two beds as transition beds. The total bed count for crisis beds and transition beds shall not exceed 29.
b. A CSP with up to 39[4] beds may designate up to three beds as transition beds. The total bed count shall not exceed 39.
c. A CSP with 40[4] or more beds may designate up to four additional beds as transition beds.

Interpretive guideline 3: It is the intent of the Division of MHDDAD that children or youth shall return to their natural environment as quickly as possible. Therefore the TOTAL LENGTH OF STAY in a CSP for any one episode of care that includes a stay in both a crisis residential bed and a transitional bed **shall not exceed 29 calendar days.**

Interpretive guideline 4[2]: CSP's shall report census and length of stay data as required to the Division of MHDDAD for both regular and transitional CSP beds.

SSr 11.6. ADVERTISING OF SERVICES

SSr.11.6. The Crisis Stabilization Program shall not advertise services offered within the CSP.

Interpretive guideline 1: The Community Service Board may inform and educate the public about services offered by the CSP, but shall not advertise any of the CSP services or hold itself out in any manner as providing inpatient or hospital service.

SSr 11.7. BILLING AND REVENUE SOURCE

SSr 11.7(a).[2.1] The primary revenue source shall be public funds.

[2.1] Modified FY02
[4.1] Modified FY04
[4] Added to CSP Standards FY04

[2] Added to CSP Standards FY02
[2.1] Modified FY02

Interpretive guideline 1: Review of fund sources for the CSP will show that no less than 95% of the funding is public, including government payers.

SSr 11.7(b). Legal guardians are billed on a sliding fee scale basis according to their ability to pay. Fees for children and youth served under the Department of Family and Children's Services or under the Department of Juvenile Justice shall be set by mutual agreement by the Departments.

Interpretive guideline 1: Review of billing practices shall demonstrate that residents' legal guardians have been billed on a sliding fee scale basis.

Interpretive guideline 2: Review of billing practices shall demonstrate that fees billed for children and youth served under the Department of Family and Children's Services or under the Department of Juvenile Justice are billed according to agreements set by the Departments.

SSr 11.8. PHYSICIAN OVERSIGHT

SSr 11.8(a). All services offered within the Crisis Stabilization Program shall be provided under the direction of a physician.

Interpretive guidelines 1: "Physician" means any person who is licensed to practice in this State under the provisions of Article 2 of chapter 34 of Title 43, or who is employed as a physician by the United States Veterans Administration or other federal agency. Rules of DHR MHMRSA ERETF 290-4-1-.01(g).

Interpretive guideline 2: The active medical staff of the CSP shall include a physician who has completed at least one year of approved psychiatric residency and consultation by a psychiatrist shall be available. Rules of DHR MHMRSA ERETF 290-4-1-.04(2)

Interpretive guideline 3: It is preferred that the CSP is under the direction of a psychiatrist with training or experience in working with children and youth.

Interpretive guideline 4: In the event that the physician providing coverage is not a psychiatrist, arrangements shall be in place for psychiatric consultation.

SSr 11.8(b) A physician shall conduct assessments of new residents, address resident care issues and write orders as required.

Interpretive guideline 1: A physician is NOT required to be on site 24 hours a day, however the physician must report to the Charge Nurse daily. A physician must be available by pager 24 hours a day and must respond to staff calls immediately, not to exceed one hour. The physician must personally report to the CSP at the request of the charge nurse.

Interpretive guideline 2: CSP's must have capacity to admit and discharge seven days a week, 24 hours per day.

Interpretive guideline 3: A physician must assess each new resident within 24 hours of admission.

Interpretive guideline 4: Documentation by the physician shall include, at a minimum, the initial evaluation of the resident, resulting diagnoses and care orders, the response to care and services provided, a rationale for medications ordered or prescribed, and assessment of the resident at the time of discharge.

SSr 11.8(c). The functions performed by physician's assistants, nurse practitioners and clinical nurse specialists are within the scope allowed by state law and professional practice acts.

Interpretive guideline 1: The CSP utilizing physician's assistants, nurse practitioners and clinical nurse specialists can demonstrate verbally and through documentation their implementation of agreements and procedures required by state law and professional practice acts. Renewal of Georgia Board of Nursing authorization as a nurse practitioner will coincide with the renewal of the registered professional nurse license.

SSr 11.9. REGISTERED NURSE OVERSIGHT

SSr 11.9(a). The Crisis Stabilization Program shall have a position classified as a lead nurse or higher that serves as the nursing administrator.

Interpretive guideline 1: The Registered Nurse designated as nursing administrator is a full-time employee of the program whose job responsibilities include, but are not limited to, clinical supervision of nursing staff and the implementation of physician's orders.

Interpretive guideline 2: It is preferred that the designated Registered Nurse administrator has training or experience with children and youth.

SSr 11.9(b). The Crisis Stabilization Program shall have a Registered Nurse present within the facility at all times.

Interpretive guideline 1: A Registered Nurse must be in the CSP facility at all times.

Interpretive guideline 2: A Registered Nurse must be the Charge Nurse at all times.

Interpretive guideline 3: There must be one Registered Nurse within the CSP facility for every 30 CSP facility beds.

SSr 11.10. STAFF TO RESIDENT RATIOS

SSr 11.10. Staff to resident ratios shall be established based on the stabilization needs of residents being served.

Interpretive guideline 1: The ratio of direct care staff to residents should not be less than one to four (1:4), including the Registered Charge Nurse.

Interpretive guideline 2: There shall always be at least three staff present within the CSP including the Charge Nurse.

Interpretive guideline 3: The utilization of licensed practical nurses shall be considered to provide technical support to the Registered Nurse.

Interpretive guideline 4: The functions performed by registered nurses and licensed practical nurses are within the scope allowed by State Law and professional practice acts.

SSr 11.11 USE OF TIME OUT

SSr 11.11(a) If "time out" or "time away" is used as a less restrictive intervention prior to using an emergency safety intervention, the "time out" or "time away" shall be used according to these guidelines.

Interpretive guideline 1: Time out may be utilized in these ways:

a. Away from the area of activity or from other residents, such as in the resident's room (exclusionary)
b. In the area of activity or other residents (inclusionary)

Interpretive guideline 2: A resident in time out must never be physically prevented from leaving the time out area.

Interpretive guideline 3: The seclusion or restraint room shall not be used for time out

Interpretive guideline 4: Staff must monitor the resident while he or she is in time out.

SSr 11.12. USE OF SECLUSION OR RESTRAINT

SSr 11.12(a). A Crisis Stabilization Program for children and youth may only use restraint and seclusion as an emergency safety intervention of last resort.

Interpretive guideline 1: In all cases, the law regarding seclusion and restraint found in O.C.G.A. 37-3 and 37-7 as well as the rules and definitions found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-6 Patients' Rights shall apply.

Interpretive guideline 2: In all cases, the rules regarding *Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs* found at 42 CFR Part 441 Subpart D and the *Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21* found in 42 CFR Part 483 Subpart G shall apply.

Interpretive guideline 3: Restraint and seclusion may not be used simultaneously.

Interpretive guideline 4: All physical restraints and seclusion shall be used solely for the purposes of providing an immediate response to an emergency safety situation

a. Restraint or seclusion must not result in harm or injury to the resident.
b. Restraint or seclusion must be used only to ensure the safety of the resident or others during an emergency safety situation.
c. Restraint or seclusion must be used only until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.
d. Restraint or seclusion shall not be used as punishment, coercion, discipline, retaliation or for the convenience of staff.

Interpretive guideline 5: Seclusion or restraint may only be used when less restrictive interventions have been determined to be ineffective.

Interpretive guideline 6: All documentation related to the safety intervention of last resort must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

a. Each order for restraint or seclusion.
b. The time the emergency safety intervention actually began and ended..
c. The time and results of the 1-hour assessment conducted by the physician or clinically qualified registered nurse.
d. The emergency safety situation that required the resident to be restrained or put in seclusion.
    a. The names of staff involved in the emergency safety intervention.
    b. All interventions utilized prior to the seclusion or restraint episode must be descriptively documented in the sequence used and identified as to the staff member conducting the intervention.

Interpretive guideline 7: CSP's must have a written policy and procedure about the use of seclusion and restraint. Evidence of annual training and competency in the proper and safe use of seclusion and restraint including techniques and alternative methods for handling behavior, symptoms and situations that traditionally have been treated through the use of restraints or seclusion must be available within staff personnel files for all staff who have direct contact with residents. Policy, procedures and training documentation evidence must include:

a. Techniques to identify staff and resident behaviors, events and environmental factors that may trigger emergency safety situations.
b. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations.
c. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or who are in seclusion.

d. Evidence of exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.
e. Evidence that staff are trained and demonstrate competency before participating in an emergency safety intervention.
f. Evidence that staff have demonstrated their competencies related to seclusion and restraint on a semiannual basis.
g. Evidence of current certification in the use of cardiopulmonary resuscitation.
h. Evidence that staff have demonstrated their competency in cardiopulmonary resuscitation on an annual basis.

Interpretive guideline 8: The CSP must document in the staff personnel records that the training and demonstration of competency were successfully completed.

a. Documentation must include the date training was completed and the name of persons certifying the completion of training

SSr11.12.(b). Notification of the CSP policy on seclusion or restraint must be given.

Interpretive guideline 1: The CSP must inform both the incoming resident and the resident's parent(s) or legal guardian(s) of the CSP's policy regarding the use of restraint or seclusion during an emergency safety situation of last resort.

Interpretive guideline 2: The CSP must communicate its restraint and seclusion policy in a language that the resident or his or her parent(s) or legal guardian(s) understands (including American Sign Language) and when necessary, the CSP must provide interpreters or translators.

Interpretive guideline 3: The CSP must obtain an acknowledgment, in writing, from the resident, the parent(s) or legal guardian(s) that he or she has been informed of the CSP's policy on the use of restraint or seclusion during an emergency safety situation. This acknowledgment must be filed in the resident's record.

Interpretive guideline 4: The CSP must provide a copy of the facility policy to the resident and to the resident's parent(s) or legal guardian(s).

Interpretive guideline 5: The CSP's policy must provide contact information, including the phone number and mailing address, for the State Protection and Advocacy organization.

SSr.11.12(c). Each resident shall be assessed for a history of past trauma or abuse.

Interpretive guideline 1: The body of the admission assessment shall contain an assessment of past trauma or abuse. The resident and his or her parent or legal guardian shall also be asked how he or she would prefer to be approached should he or she become dangerous to themselves or to others. Findings from these queries shall inform the decision making process about the plan of care.

Interpretive guideline 2: Emergency safety interventions must be performed in a manner that is safe, proportionate and appropriate to the severity of the behavior, and the resident's

chronological and developmental age, size, gender, physical, medical and psychiatric condition and personal history (including any history of physical or sexual abuse).

SSr 11.12(d).[5.1] A physician or other licensed practitioner permitted by the State shall give an order for the seclusion or restraint episode as soon as possible within the first fifteen minutes of the implementation of seclusion or restraint intervention.

Interpretive guideline 1: Orders for restraint or seclusion must be by a physician or other licensed practitioner permitted by the State and CSP.

Interpretive guideline 2[5.1]: The physician or Clinical Nurse Specialist (CNS) must be notified immediately of the seclusion or restraint episode. The physician or CNS must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

Interpretive guideline 3: If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other staff licensed to receive orders, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends.

a. If the treating physician is not available to order the use of restraint or seclusion, the physician's verbal order must be obtained.
b. The physician ordering the restraint or seclusion must verify the verbal order in a signed written form in the resident's record as soon as possible.
    i. If the physician or CNS giving the order is not the resident's treating physician, the physician or CNS must consult with the treating physician as soon as possible and inform the treating physician of the emergency safety situation;
    ii. Staff must document in the resident's record the date and time the treating physician was consulted.

Interpretive guideline 4: Each order for restraint or seclusion must:

a. Be limited to no longer than the duration of the emergency safety situation.
b. Specify the time limits for the restraint or seclusion episode. Under no circumstances shall an order exceed :
    i. Four (4) hours for residents ages 17 and above;
    ii. Two (2) hours for residents ages 9 to 17;
    iii. One (1) hour for residents under age 9.
c. Specify the behavioral indicators that signal the end of the episode.
d. State that the restraint or seclusion episode shall be ended at the earliest possible time.

Interpretive guideline 4: If the emergency safety situation continues beyond the time limit of the physician's order for the use of restraint or seclusion, a registered nurse must immediately contact the ordering physician in order to receive further instructions.

[5.1] Modified FY05
[5.1] Modified FY05

Interpretive guideline 5: Each order for restraint or seclusion must include:

a. The name of the ordering physician or CNS;
b. The date and time the order was obtained;
c. The emergency safety intervention ordered;
d. The length of time for which the physician authorized its use;
e. The behavioral indicators that signal the end of the episode.

The restraint or seclusion episode shall be ended at the earliest possible time.

Interpretive guideline 6: Orders for restraint or seclusion may not be written as a standing order or as an as-needed basis.

SSr 11.12(e).[6.1] A physician or clinically qualified registered nurse must personally examine the resident within one (1) hour of the initiation of the emergency safety intervention and immediately upon the end of the seclusion or restraint episode.

Interpretive guideline 1[5.1]: The physician or clinically qualified registered nurse must personally examine the resident within one hour of the initiation of the emergency safety intervention and immediately upon the end of the seclusion or restraint episode. The findings of the examination of the resident shall be documented in the resident record and must include the resident's physical and psychological well being, including but not limited to:

a. The resident's physical and psychological status.
b. The resident's behavior.
c. The appropriateness of the intervention measures.
d. Any complications resulting from the intervention.

Interpretive guideline 2: If the resident is released from seclusion or restraint prior to the end of the first hour *and* prior to the personal examination of the physician or clinically qualified registered nurse, the rationale for release of the resident *and* the fact that the resident was not personally seen by a physician shall be fully documented within the resident record.

Interpretive guideline 3[5.1]: After the order expires, a new determination for continued seclusion or restraint may be made ONLY after the resident is PERSONALLY examined by a physician or a clinically qualified registered nurse and may be ordered by a physician or CNS for an additional specific time episode not to exceed:

a. Four (4) hours for residents ages 17 and above;
b. Two (2) hours for residents ages 9 to 17;
c. One (1) hour for residents under age 9.

SSr 11.12(f). During the seclusion or restraint episode, clinical staff trained in the use of emergency safety interventions must be physically present, continuously monitoring the

[6.1] Modified FY06

physical and psychological well-being of the resident and the safe use of restraint or seclusion, and shall document findings and care given every 15 minutes.

Interpretive guideline 1: A staff member must be assigned to be present immediately outside the seclusion door and must continuously visually monitoring the resident when seclusion is utilized.

Interpretive guideline 2: A staff member must be assigned to be present at all times within the room and the door to the room left open when a resident is restrained.

Interpretive guideline 3: A resident placed in physical restraints must be checked at least every 15 minutes by staff members trained in the use of restraints, and a written record of these checks and all other activities shall be made.

Interpretive guideline 4: While in restraints each person should be spoken to, checked for indications of obvious physical and psychological distress, be offered liquids and an opportunity to meet his need to urinate and defecate as needed or at least every 2 hours unless the person is asleep or his condition does not permit. The restraints sites should be checked every hour for evidence of swelling or abrasion. Each hour a restraint should be removed from each limb for five minutes and then reapplied if his condition permits. A person in restraints should receive all meals available to other patients except as otherwise ordered by a physician based upon the person's health needs and as his condition to take meals while in restraints. In all situations, the resident must receive nutrition at regular meal intervals unless refused by the resident. Restraints are to be discontinued when they are no longer needed to prevent a person from hurting himself or others and his medical needs allow removal.

Interpretive guideline 5: Video monitoring does not meet the requirement of personal monitoring of the resident while in seclusion or restraints.

Interpretive guideline 6: The physician must be available to staff for consultation at least by telephone throughout the period of the emergency safety intervention.

SS 11.12(g). Notification of the use of seclusion or restraint shall be given to the parent(s) or legal guardian(s).

Interpretive guideline 1: The CSP must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

Interpretive guideline 2: The CSP must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention including the date and time of notification and the name of the staff person providing the notification.

SSr 11.12(h). Staff shall conduct a debriefing with the resident within 24 hours after release from seclusion or restraint.

Interpretive guideline 1: The resident shall have an opportunity to talk to staff members within 24 hours after release from seclusion or restraint. This discussion must include staff involved in the intervention except when the presence of a particular staff person may jeopardize the well being of the resident. The discussion may include supervisory and administrative staff if appropriate.

Interpretive guideline 2: The following are potential issues to explore with the resident:

a. Circumstances resulting in the use of seclusion or restraint, including:
    i. What the resident remembers happening prior to becoming angry, destructive or self injurious.
    ii. Whether the resident remembers sensory changes prior to being placed in seclusion or restraints.
    iii. What thoughts the resident has about why the resident was placed in seclusion or restraint.
    iv. How the resident felt while in seclusion or restraint.
    v. How the resident felt after being released from seclusion or restraint.
b. The outcome of the interventions used, including any injuries that may have resulted from the use of seclusion or restraint.
c. Strategies to be used by the staff, the resident or others that could prevent the future use of restraint and seclusion.
a. Alternative techniques might have prevented the use of seclusion or restraint.
d. Procedures, if any, that staff should implement to prevent any recurrence of the use of restraint or seclusion.
e. Strategies that were helpful to the resident in gaining personal control:
    i. Was there something the resident did that was helpful in gaining personal control?
    ii. Was there something the staff did that was helpful in the resident gaining personal control?

Interpretive guideline 3: Staff must document in the resident's record that debriefing took place and must include:

a. The names of staff who were present for the debriefing.
b. The names of staff who were excused from the debriefing.
c. Any changes to the resident's treatment plan that results from the debriefing.

SSr 11.12(i). The staff members involved in the seclusion or restraint episode shall receive a debriefing after the episode.

Interpretive guideline 1: Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention and appropriate supervisory and administrative staff must conduct a debriefing session that includes, at a minimum, a review and discussion of:

a. The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention, such as:
    i. What physical cues were present that indicated escalation of resident behaviors?

b. Review of techniques used and alternative techniques that might have prevented the use of the restraint or seclusion:
    i. What interventions were conducted, by what staff member and in what order as the events unfolded leading up to seclusion or restraint?
    ii. What was the resident response to each intervention conducted?
    iii. Could alternate interventions resulted in a different outcome other than seclusion or restraint?
c. What did the staff involved do well?
d. What could staff do differently in the future that might avoid reaching the point of a seclusion or restraint?
e. What recommendations shall be documented within the resident plan of care for use in future situations?

Interpretive guideline 2: Staff must document in the resident's record that debriefing took place and must include:

a. The names of staff who were present for the debriefing;
b. The names of staff who were excused from the debriefing;
c. Any changes to the resident's treatment plan that results from the debriefing.

Interpretive guideline 3: Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

SSr 11.13 MEDICAL TREATMENT FOR INJURIES RESULTING FROM A SAFETY INTERVENTION

SSr 11.13 The CSP shall insure that medical treatment is immediately obtained from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

Interpretive guideline 1: Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

Interpretive guideline 2: Staff must document in the resident's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff from that intervention.

SSr 11.14 ORGANIZATIONAL RISK AND COMPLIANCE

SSr 11.14 The CSP has a well-defined approach for assessing its performance, for anticipating, identifying, correcting and solving problems, and for improving quality of care related to use of safety interventions of last resort.

Interpretive guideline1: The CSP maintains a record of each emergency safety situation, the interventions used, and their outcomes.

Interpretive guideline 2: Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Interpretive guideline 3: Data regarding the use of safety interventions of last resort will be aggregated and reported quarterly to the CSP management and risk management authority of the managing Community Service Board or State Hospital facility. The report shall include issues that have been addressed pursuant to review of the data, or that no action is required based on aggregate information.

Interpretive guideline 4 : Each CSP with a current Medicaid provider agreement must provide to the State Medicaid agency, at the time it executes a provider agreement with the Medicaid agency, in writing, that the CSP is in compliance with CMS's standards governing the use of restraint and seclusion. The CSP director must sign this attestation.

SSr 11.15 PHARMACY SERVICES

SSr 11.15 All pharmacy operations or services within the CSP must be licensed and under the direct supervision of a Registered Pharmacist or provided by contract with a licensed pharmacy operated by a Registered Pharmacist.

Interpretive guideline 1: Pharmacy services must be provided under the license and supervision of a Registered Pharmacist who is operating under a 'retail' or 'hospital' license.

Interpretive guideline 2: Any request for exemptions for requirements regarding a pharmacy license must be submitted in writing to the Georgia State Board of Pharmacy.

SSr 11.16. MEDICATION ADMINISTRATION

SSr 11.16 In all cases, the rules regarding medications found in Rules of Department of Human Resources, Mental Health, Mental Retardation and Substance Abuse Chapter 290-4-9 Residents' Rights shall apply.

Interpretive guideline 1: Medications shall be used solely for the purposes of providing effective treatment and protecting the safety of the resident and other persons and shall not be used as punishment, coercion, discipline, retaliation or for the convenience of staff.

Interpretive guideline 2[6]*:* The CSP shall follow policies and procedures found in the Division of MHDDAD Policy 2:100, *Informed Consent for Psychotropic Medication,* concerning the use of psychotropic medications and the use of involuntary medications.[6]

[6] Added FY06

SSr 11.17 INDIVIDUALIZED CARE

SSr 11.17. Educational and program offerings within the CSP include services to meet the individual stabilization needs of each resident including psychiatric or behavioral stabilization for children and youth who are seriously emotionally disturbed and detoxification services for youth. Educational and program offerings shall also include attention to the child or youth's academic development.

Interpretive guideline 1: Educational and program offerings include offerings that address issues both common and distinct to the child or youth needing psychiatric or behavioral stabilization and for the youth needing detoxification services.

Interpretive guideline 2: Each child or adolescent shall be assessed to determine his or her academic development. The CSP shall utilize educational integration services has a mechanism to support and enhance the child or adolescent's academic development.

a. Educational specialists or teachers will be available to provide instruction and support services such as tutoring;
b. Individualized planning and linkage shall occur with child or youth's community school.

Interpretive guideline 3: Educational, program and academic offerings are age appropriate and presented in a way easily understood by the resident.

Interpretive guideline 4: The resident's clinical record will demonstrate individualized interventions based on the care needs of each person served as evidenced within the body of assessments, documentation of the progression of care and documented discharge linkages.

Interpretive guideline 5: A record of academic assessment, offerings and the child or youth's response to those offerings shall be maintained in a separate record that shall be filed with the clinical record at discharge.

Interpretive guideline 6: Staff training records shall show evidence of annual training and competency in caring for children or youth needing psychiatric or behavioral stabilization and for the youth needing detoxification services.

SSr.11.18 REPORTING OF SERIOUS OCCURRENCES

SSr.11.18. The CSP must report each serious occurrence.

Interpretive guideline 1: Serious occurrences shall be reported as specified in Policy 2:101 of the Division of MHDDAD, *Reporting and Investigating Consumer Deaths and other Serious Incidents.*

Interpretive guideline 2: The CSP must report any serious occurrence to both the State Medicaid agency and, unless prohibited by law, the State-designated Protection and Advocacy system. Serious occurrences that must be reported include:

a. Resident's death
b. Resident's suicide attempt
c. Serious injury to a resident manifesting itself as any serious impairment of the physical condition of the resident as determined by qualified medical personnel including, but not limited to:
    i. Burns
    ii. Lacerations
    iii. Bone fractures
    iv. Substantial hematoma
    v. Injuries to internal organs, whether self-inflicted or by someone else

Interpretive guideline3: The CSP shall notify the resident's parent(s) or legal guardian(s) as soon as possible and in no case later than 24 hours after a serious occurrence.

Interpretive guideline 4: A description of the serious occurrence must be recorded in the resident's record, including:

a. Medical treatment sought, outcome of treatment, and follow-up required;
b. That the serious occurrence was reported, including
    i. The names of the parent(s) legal guardian(s) to whom it was reported
    ii. The name of the agencies to which it was reported, including the name of the person at the agency who received the report.
        1. The State Medicaid Agency (if the CSP is enrolled as a Medicaid provider)
        2. The State Protection and Advocacy system
        3. The Division of MHDDAD

Interpretive guideline 5: In addition to the agencies listed above, if the CSP is enrolled as a Medicaid provider, ALL DEATHS of any resident must be reported to the Regional Office for the Centers for Medicare and Medicaid (CMS) by no later than the close of the next business day after the resident's death.

a. The method of reporting and corresponding documentation noted within this standard shall apply.
b. Staff must document in the resident's record that the death was reported to the CMS regional office.

Interpretive guideline 6: A copy of the incident and accident report shall be kept by the CSP.

SSr. 11.19 REPORTING OF CLIENT DATA TO THE DIVISION OF MHDDAD[7]

SSr.11.19. The crisis stabilization program shall report data to the Division of MHDDAD as directed by provider agreement.

[7] Added to CSP Standards FY07

Interpretive guideline 1: Encounter data shall be reported to the Division of MHDDAD in the format directed by the operational guidelines provided by the Division of MHDAD to the parent organization (Community Service Board or State Hospital Facility).

Interpretive guideline 2: Encounter data shall include but may not be limited to:

a. Client name
b. Date of admission
c. Date of discharge
d. Legal status
e. Admitting diagnosis
f. Referred to

SSr. 11.20 DESIGNATION AS A CRISIS STABILIZATION PROGRAM

SSr 11.20. The designation must be approved and may be withdrawn by the department. Designation is not transferable.

Interpretive guideline 1: Designation as a crisis stabilization program must be approved and may be withdrawn by the department. Designation is non-transferable.

Interpretive guideline 2: Each designation or provisional designation shall be returned to the department in the following cases. This includes but may not be limited to:

- Change in location
- Program closure
- DHR finding of failure to comply with CSP standards
- Loss of accreditation